LEGISLATIVE SERVICES AGENCY
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FISCAL IMPACT STATEMENT

LS 7525
BILL NUMBER: SB 472

NOTE PREPARED: Mar 31, 2009
BILL AMENDED: Mar 30, 2009

SUBJECT: Indiana Check-up Plan.

FIRST AUTHOR: Sen. Miller
FIRST SPONSOR: Rep. C. Brown

BILL STATUS: CR Adopted - 2nd House

FUNDS AFFECTED:
GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill allows certain individuals to participate in the Healthy Indiana Plan (HIP) without state funding.

The bill provides that to be eligible for participation in the plan that the individual has not had health insurance coverage for three months. (Current law requires six months without health insurance.)

The bill also provides that an individual's income eligibility for dental or vision coverage under the Indiana Check-up Plan is based on annual adjusted gross income. (Current eligibility is based on annual household income.)

The bill allows money in the individual's health care account to pay for over-the-counter medicines and personal hygiene items.

It allows an individual access to noncontracted licensed Medicaid providers.

The bill also prohibits an employer from terminating employee health insurance for the purpose of having employees receive coverage under the plan.

It also allows a nonprofit organization and certain health care insurers and health maintenance organizations to contribute to the health care account of a HIP participant under certain circumstances.

The bill specifies that the minimum amount paid by certain plan participants into the participant's health care account is $60.

The bill repeals a provision allowing individuals to obtain health care coverage that is the same as the HIP if the plan has reached maximum enrollment using standard underwriting practices.

The bill requires the Secretary of Family and Social Services to report to the Select Joint Commission on Medicaid Oversight before September 1, 2009, on; (1) the status of the Disproportionate Share Hospital (DSH) program and any changes needed for the system; and (2) the establishment of the enhanced payments for medical education and critical needs hospitals.

Effective Date: Upon passage; July 1, 2009.

Explanation of State Expenditures: *HIP Minimum Contribution:* The bill would require a minimum contribution of $5 per month from all participants in the HIP program. Currently, approximately 14,000 individuals with incomes below 100% of the FPL are exempted from making sliding scale-based payments into their health savings account. This provision would result in annual health savings account deposits of $840,000 being made by participating individuals, reducing the federal and state subsidy.

(Revised) *Adjusted Gross Income Premium Limit for Dental and Vision Coverage:* Currently, the HIP program does not offer dental or vision coverage under the HIP Medicaid waiver due to cost considerations. If dental and vision coverage would be offered in the future, the adjusted gross income standard differs from the graduated household income standard used to determine the HIP premium cap. This would require FSSA to calculate and apply two different income standards in determining premium caps.

(Revised) *HIP Participant Access to Noncontracted Licensed Providers:* This provision would require that HIP participants have access to any willing provider that is licensed and is a Medicaid provider. Currently, noncontracted providers are treated as out-of-network providers, requiring the patient to pay a portion or all of the cost depending on the services received from the provider. FSSA reports that individuals may not use the Health Care Account to pay for services not covered by the plan. The provision appears to also allow HIP participants to access any provider outside the selected managed care network for services, negating the ability of the plans to manage the care of their insureds. Managed care organizations control the cost within their networks by contracting with providers who agree to comply with prior authorization and utilization management requirements. As this provision relates to chiropractic services, FSSA has estimated the cost to be an additional $2.5 M to the HIP benefit plan.

Several provisions of the bill could potentially require the Office of Medicaid Policy and Planning to prepare and submit a Medicaid waiver amendment for the HIP program to the federal Centers for Medicare and Medicaid Services. Preparation and submission of waiver amendments is considered to be administrative in nature and should be accomplished within the existing level of resources available to OMPP.

(Revised) *Reduction in Time Period Without Insurance Coverage:* This provision would allow an individual to qualify for HIP coverage if they have not had health insurance coverage for three months. Currently, an individual must have been without coverage for six months. FSSA has reported that this provision will have no fiscal impact.

(Revised) *Power Account Coverage for Over-the-Counter Medications and Personal Hygiene Items:* This provision adds a benefit to the HIP Plan that was not included in the actuarial determination of the cost of the plan. FSSA reports that over-the-counter drugs are not currently a covered benefit and may not be paid for with funds from the Health Care Account. Although the term “personal hygiene item” is not defined in

the bill, it would likely include a wide range of products and would constitute an additional benefit to the HIP. Increasing the numbers of items that may be paid for with the HIP Health Care Account would allow for faster depletion of the Accounts and greater cost to the insurance portion of the plan. Increased costs to the state might not be realized immediately under the capitation agreements for the HIP, but eventually costs related to the expansion of the benefit will be passed through to the state by actuarially determined capitated managed care payments.

(Revised) *HIP Assistance or Incentives:* The bill would allow a not-for-profit organization that is not affiliated with a health care plan to contribute up to 75% of an individual's required premium payment. This provision would allow not-for-profits to provide some assistance to HIP enrollees either on a temporary or long-term basis. The bill would also allow an insurer or managed care organization contracted with the OMPP to provide rewards as incentives. The bill specifies that the incentives cannot be given to induce an individual to receive services from a particular health care provider or facility. Rewards must be deposited in the individual's health care account, or if the account is fully funded, it may be provided directly to the individual. The provision would have no fiscal impact on the state.

Additionally, insurers or health maintenance organizations that contract with the OMPP to provide coverage under HIP are prohibited from distributing information or materials related to a specific health care provider or facility to an eligible individual or participant.

Unsubsidized Participation in HIP: The bill would allow an otherwise qualified individual to participate in the HIP coverage with no state subsidy, either because the program has reached maximum enrollment or the individual has too much income. Under this HIP option, the benefit plan would not include the $500 of state-provided qualifying preventive care services. The bill would require that individuals participating under this option contribute $1,100 to the individual's health care account and any other costs associated with participation in the HIP program.

Explanation of State Revenues: (Revised) The state share of the Medicaid match for the Healthy Indiana Plan is funded with dedicated cigarette tax dollars. The amount of state match required for the HIP will be temporarily reduced until December 2010, due to Medicaid stimulus funding made available by the American Recovery and Reinvestment Act.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: OMPP, FSSA.

Local Agencies Affected:

Information Sources: OMPP, FSSA.

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